



# MEDICAL EXAMINER

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04D-0388  
Jaden Paige  
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## Autopsy Report

### General Information:

This 8 month old black male became unresponsive while in the care of his baby sitter. He was admitted to Eggleston Hospital on March 18, 2004 where closed head injury was diagnosed. On March 21<sup>st</sup> Jaden was determined to be brain dead and a suitable candidate for organ donation.

Prior to this examination the heart was procured by the staff of Lifelink of Georgia. Following this procedure and under the provisions of the Georgia Death Investigation Act, an autopsy is performed in the DeKalb County Forensic Science Center on Monday, March 22, 2004 commencing at 8:00 am.

### External Examination:

The body is brought to the morgue wrapped in a white sheet and is otherwise unclad. No jewelry is seen on the remains.

The following medical devices are observed on the body:

1. Intracranial pressure monitoring device in the right frontal scalp.
2. Clear tape overlying the closed eyelids.
3. Endotracheal tube in the mouth.
4. IV catheters in the:
  - a. Volar aspect of the right wrist.
  - b. Dorsal aspect of the left foot.
5. Foley catheter in the urethra, which is knotted and not attached to a urinary drainage bag.
6. Hospital identification band in the name of Jaden Paige encircling the right ankle.
7. Lifelink toe tag in the name of Jaden Paige affixed to the right great toe.

INJURIES WILL BE DESCRIBED IN A SEPARATE SECTION.



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## External Examination, continued:

This is the body of a black male child that has the following measurements:

Height-26" (25<sup>th</sup> percentile)  
Weight-24 pounds 7 ounces (75<sup>th</sup> percentile)  
Head circumference-18" (75<sup>th</sup> percentile)  
Chest circumference-16-3/8"  
Abdominal circumference-14"

Rigor mortis is generalized but poorly developed. Livor mortis is dorsal and nonfixed. No other decompositional changes are seen. The overall appearance is that of a well developed and well nourished appearing black male child consistent with given age of 8 months.

The head hair is black, curly and has been recently shaved in the right frontal area where the intracranial pressure monitoring device exits the scalp. The irides are brown. Conjunctival petechiae and scleral icterus are not seen. Examination of the external auditory canals is unremarkable. Dried blood is found in the nares. There are no erupted teeth or intraoral wounds.

The neck is symmetrical and shows no external evidence of injury.

Examination of the chest demonstrates a midline vertically oriented organ procurement incision measuring 4-1/8" in length. The abdomen is slightly distended. The back reveals patterned lividity.

There are no palpable fractures in the upper or lower extremities. All digits are present. The fingernails are very short, intact and clean.

No edema of the ankles is apparent.

The external genitalia are those of a prepubescent male with descended testes.

Hypospadias is evident.



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## DESCRIPTION OF INJURIES:

### Radiographic Examination:

Total body x-rays done in the Medical Examiners office show no evidence of soft tissue calcification, recent or remote fractures. However, it is important to note that the skeletal survey performed at Eggleston Hospital revealed a cortical irregularity involving the proximal right tibia.

### Head:

There are no external signs of head trauma.

The skin of the scalp is reflected in the standard fashion to reveal three areas of intrascapular and subgaleal hemorrhage. One of these is located adjacent to the posterior sagittal suture just to the right of the midline and measures  $\frac{1}{2} \times \frac{1}{2}$ ". Another is found adjacent to the posterior sagittal suture just to the left of the midline and measures  $\frac{1}{2} \times \frac{1}{2}$ ".

The third is located in the left posterior occipital scalp and also measures  $\frac{1}{2} \times \frac{1}{2}$ ".

Furthermore, there is one additional area of intrascapular and subgaleal hemorrhage measuring 1 x 1". However, this hemorrhage is associated with the intracranial pressure monitoring device and probably does not represent an inflicted impact.

There are hemorrhagic diastatic fractures of the left frontal suture ( $1\frac{1}{2}$ " ), right frontal suture (1"), the entire sagittal suture, the left lambdoid suture (2") and the right lambdoid suture ( $\frac{1}{2}$ ").

The calvarium is otherwise intact and upon its opening the dura is very tense and distended. There is no evidence of epidural hemorrhage, however, frontal area subdural hemorrhage can be seen over both convexities.

The massively edematous 1,150 gram brain is remove with great difficulty and is fixed in formalin prior to further examination.

After removal of the brain from the cranial vault, thin layer subdural hemorrhage occupies the entire left middle cranial fossa, approximately 50% of the left posterior cranial fossa with slight extension over the midline and has a patchy distribution in the right middle cranial fossa.



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## Head, continued:

This hemorrhage shows slight adherence to the overlying dura, which may represent early organization (to be determined microscopically).

The dura is reflected from the base of the skull and retained and no fractures are found.

## Posterior Dissection:

A posterior dissection is undertaken from the occipital scalp to the Achilles tendons and also including the upper extremities. The only soft tissue hemorrhage seen is just below the right knee, in the proximal tibial area and it measures 1 x 1" (see Appendicular Skeleton).

## Internal Examination:

### Neck:

The skin of the neck is dissected up to the angle of the jaw in a step by step layerwise dissection of the soft tissues is undertaken. No evidence of bruising is seen at any point. The hyoid bone, thyroid cartilage and cervical spine are intact. No obstructing foreign matter is found in the trachea. The thyroid gland is free of gross pathology.

### Chest and Abdomen:

The skin of the chest and abdomen is opened with a Y-shaped incision in part using the organ procurement incision described previously. Except for bisection of the sternum, the bony thorax is otherwise intact. Small unmeasured amounts of bloody fluid are found in the thoracic cavities and what remains of the pericardial sac.

The thoracic and abdominal organs are examined in situ and removed by the Virchow technique. Individual organ examinations are as follows.

### Heart:

The heart is surgically absent.



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## **Lungs:**

The right lung weighs 63.2 grams and the left lung 51.1 grams. Both lungs show diffuse congestion and edema, particularly in the dependent portions. No evidence of consolidation or neoplasm is seen.

## **Urinary Tract:**

The right kidney weighs 21.5 grams and the left kidney 20.0 grams. Both kidneys display fetal lobulation. The capsules strip with ease. The cortices and medullae are well demarcated. The parenchyma is congested. The collecting systems are patent from the calyces to the urinary bladder (Foley catheter).

Sectioning of the prostate gland and testes reveals no evidence of trauma.

## **Gastrointestinal Tract:**

The stomach and esophagus are free of mucosal ulcerations and empty. The remainder of the intestines is opened from the duodenum to the rectum and is free of ulceration, neoplasm and infarct. The vermiform appendix is grossly normal.

The 270 gram liver has an intact capsule and slightly congested parenchyma. The distended gallbladder contains approximately 20 cc of bile. The extrahepatic biliary tree is patent.

## **Spleen:**

The 49.6 gram (range of normal weights for sex and age is 20 +/- 7 grams) spleen has an intact capsule and quite softened and congested parenchyma.

## **Pancreas and Adrenal Glands:**

No gross pathology is evident.

## **Lymphatic System:**

There is no significant lymphadenopathy.

## **Axial Skeleton:**

Except for the diastatic fractures, no other gross pathology is observed.



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## Appendicular Skeleton:

The proximal 3<sup>rd</sup> of the right tibia is excised and fixed in formalin prior to further examination. After decalcification, the proximal tibia is sectioned longitudinally along its long axis. These sections reveal intramedullary hemorrhage as well as hemorrhage in the adjacent soft tissues and beneath the periosteum.

## Thymus Gland:

The thymus gland weighs 14.4 grams and has the usual butterfly configuration.

## MICROSCOPIC DESCRIPTION:

### Key to sections:

- Block #1-right parietal bruise
- Block #2-left parietal bruise
- Block #3-left occipital bruise
- Block #4-left posterior cranial fossa dura
- Block #5-left middle cranial fossa dura
- Block #6-right tibial bruise

## Right Parietal Bruise:

Present in this section is a segment of hair bearing skin showing a modest amount of recent hemorrhage along with unorganized blood clot in the subcutaneous tissues. Inflammation in association with this hemorrhage is minimal and consists primarily of nuclear debris associated with the blood clot.

## Left Parietal Bruise:

Histologic features seen in this section are nearly identical to those found in the right parietal bruise.

## Left Occipital Bruise:

Present in this section of subcutaneous tissue is a small dense hematoma associated with minimal acute inflammation. The red blood cell contours are generally intact and no evidence of organization is seen.





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## Right Posterior Cranial Fossa Dura:

Sections in this region of dura show a large recent subdural hematoma with no evidence of organization. At the interface between the dura and blood clot, no fibroblastic proliferation or neovascularization is present. The red blood cells comprising the hematoma are generally intact.

## Left Middle Cranial Fossa:

Sections of dura from this area show a large subdural blood clot of recent origin. At the interface between the blood clot and dura there is early fibroblastic proliferation. The red blood cells comprising the hematoma are generally intact. In one section of the dura there is a benign lymphoid aggregate of unknown clinical significance.

## Right Proximal Tibial Area:

A section of soft tissue from this region shows recent hemorrhage in the subcutaneous fat. In some areas this hemorrhage is associated with early acute inflammation.

## Right Proximal Tibia:

Present in these sections is intramedullary hemorrhage as well as periosteal and subperiosteal hemorrhage consistent with recent fracture. Disruption of the cortex in the proximal diaphysis is apparent. No evidence of healing is found.

## Pituitary Gland:

The gland exhibits intense vascular congestion particularly in the areas that demonstrate recent bland infarct.

## Lungs:

Both lungs display intense vascular congestion. Many of the large, medium and small airways are packed with neutrophils as are some of the alveolar spaces. There is generalized atelectasis. Focal aggregates of benign mononuclear inflammatory cells are scattered throughout the parenchyma. Other alveolar spaces are filled with a combination of fibrin, edema fluid and neutrophils.



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## Liver:

The hepatic architecture is preserved. Acute central venous congestion is seen. There is no significant steatosis. Hepatitis is not apparent.

## Kidneys:

No significant glomerular, tubular, vascular or interstitial pathology is found.

## Spleen:

The sinusoids are congested. The white pulp is benign. Evidence of sequestration is not found.

## Thymus Gland:

No pathologic diagnosis.

In some of the adjacent soft tissues, there is recent hemorrhage without evidence of inflammatory response.

## Pancreas:

No fibrosis or inflammation is seen. Normal numbers of islets are identified.

## Adrenal Glands:

There is no evidence of cortical lipid depletion or medullary hemorrhage.

## Thyroid Gland:

The follicular epithelium is active and not inflamed. An incidental parathyroid gland shows no histopathology.

## Bone Marrow:

The bone marrow is 50-60% cellular. There is orderly maturation of the erythroid and myeloid series. Adequate numbers of megakaryocytes are identified.





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## Prostate Gland:

No pathologic diagnosis.

## Testes:

Infantile tubules without spermatogenesis are apparent.

## Axillary Lymph Nodes:

The lymph node architecture is preserved. Active germinal centers are seen. no inflammation or neoplasm is found.

## Esophagus, Stomach, Intestine & Urinary Bladder:

No pathologic diagnosis.

## Right and Left Eyes:

Recent perioptic nerve hemorrhage is seen bilaterally. In addition, multiple small and large recent hemorrhages involving all layers of the retina in both eyes are observed.

## Brain:

See "Neuropathology Report".



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## Summary of Findings:

1. Craniocerebral trauma (also see Neuropathology Report).
  - A. Multiple at least (three) blunt impacts of the head resulting in intrasclalular and subgaleal hemorrhage.
  - B. Diffuse cerebral edema associated with diastatic skull fractures, bilateral transtentorial and cerebellar tonsillar herniation.
  - C. Recent subdural and subarachnoid hemorrhage.
  - D. Multiple cerebral infarcts including the pituitary gland.
  - E. Diffuse axonal injury.
  - F. Multiple bilateral retinal hemorrhages (all layers).
  - G. Bilateral perioptic nerve hemorrhage.
  - H. Acute bilateral bronchopneumonia.
  - I. Status post multiple diagnostic, therapeutic and or resuscitative procedures with associated injuries/artifacts.
2. Recent diaphyseal fracture of the right proximal tibia.
3. Sickie Beta Thalassemia with splenomegaly.
4. Status post procurement of the heart.
5. No evidence of any other significant recent natural disease processes in the remaining organs and tissues.



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## Other Procedures:

1. Blood for toxicology (State Crime Laboratory). Negative for ethanol and common drugs of abuse.
2. Sick cell prep (negative).
3. Metabolic screen (acylcarnitine profile-within normal limits).
4. Documentary photographs are taken.
5. Sectioned organs are forwarded with the body.
6. The case is discussed with Investigators Sam Buice and Woody Hall during the examination.
7. The following medical records are reviewed:
  - a. Northside Hospital (birth).
  - b. Grady Hospital (sickle cell clinic).
  - c. Scottish Rite Hospital.
  - d. Egleston Hospital.

## Cause of Death:

Craniocerebral trauma

## Manner of Death:

Homicide

## Summary and Opinions:

This 8 month old black male started to cry and then became unresponsive according to his baby sitter. These events occurred at approximately 10:00 am on March 18, 2004. Jaden had been with the sitter in his usual state of good health for the preceding four hours. Emergency medical personnel were summoned. The initial Glasgow Coma Scale was 5, O2 saturation 93%, B/P 107/74, pulse 132 and respiratory rate 10. He was transported to the Egleston Hospital emergency room.

Evaluation at Egleston revealed a left subdural hemorrhage with left to right midline shift and bilateral retinal hemorrhages. There was no enlargement of the liver or spleen by physical examination. The BUN was 9, creatinine-0.3, sodium-135, potassium-4.3, chloride-107, CO2-14 and total bilirubin-0.7. The initial hemoglobin was 10.0, hematocrit 28.8 and platelet count 201,000. Shortly after admission the hematocrit fell to 15.4. With blood transfusions the hematocrit stabilized in mid to low 30's. He was thought to be functionally exchanged which probably explains the negative postmortem sickle cell prep.



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## Summary and Opinions, continued:

He was admitted to the intensive care unit hypotensive and bradycardic. Shortly thereafter he suffered a reversible cardiorespiratory arrest. For the remaining three days of hospitalization, he required mechanical ventilation and vasopressors. Complications of diabetes insipidus and coagulopathy developed. Jaden was determined to be clinically brain dead on March 21<sup>st</sup> at 10:25 am. He was a suitable candidate for organ donation. Subsequently, the heart was procured by the staff of Lifelink of Georgia. After this procedure, the remains were transported to the DeKalb County Medical Examiners Office for further examination. The final diagnoses at Egleston were child physical abuse and sickle cell thalassemia, not in crisis.

Jaden was born prematurely at 35 weeks estimated gestational age on June 25, 2003. He was delivered vaginally at Northside Hospital and his birth weight was four pounds five ounces. It was reported that his mother had received prenatal care that was unremarkable. The only physical abnormality noted at birth was hypospadias. A very extensive metabolic screen was entirely within normal limits. The initial hemoglobin analysis was positive for sickle cell disease or Sickle Beta Thalassemia.

He was followed up in the pediatric sickle cell clinic on August 15, 2003. At that time he had no complaints. The hemoglobin was 8.5 and the hematocrit 24.9. He was referred to a urologist for hypospadias.

Jaden was next seen in the pediatric sickle cell clinic on October 13, 2003. At that time it was determined that his immunizations were up to date. He had grown to where his height was in the 56 percentile and weight in the 62 percentile.

On February 10, 2004, Jaden was admitted to Scottish Rite Hospital with an enlarged spleen and low grade fever. At that time the hemoglobin was 5.4 and the hematocrit 17.2. The working diagnosis was splenic sequestration. He was treated with intravenous fluids, two blood transfusions and antibiotics. He responded well and was discharged on February 15, 2004.

Jaden received a 3<sup>rd</sup> blood transfusion as an outpatient on March 12, 2004. Since his last transfusion he had been well except for mild upper respiratory symptoms. His next contact with medical profession was March 18, 2004 Egleston admission.



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## Summary and Opinions, continued:

The autopsy revealed at least three blunt impacts to the head resulting in intrasclalular and subgaleal hemorrhage as described in detail in the text of this report. Associated with these blunt impacts to the head was marked cerebral edema and recent subdural and subarachnoid hemorrhage. Only the subdural hemorrhage involving the left middle cranial fossa demonstrated evidence of organization and this was minimal. The cerebral edema resulted in or further aggravated diastatic skull fractures. In addition, bilateral transtentorial and cerebellar tonsillar herniation and multiple cerebral infarcts including the pituitary gland were evident.

Diffuse axonal injury was demonstrated by beta amyloid precursor stains on selected areas of the brain (See Neuropathology Report).

Furthermore, there was a recent fracture of a diaphysis of the proximal right tibia that showed no histologic evidence of healing.

Acute bilateral bronchopneumonia was probably the result of neurologic dysfunction and mechanical ventilation.

There was no autopsy evidence of splenic sequestration or sickle cell crisis.

In summary, Jaden died as a result of craniocerebral trauma and its complications.

In the opinion of the undersigned, his previously diagnosed hematologic condition did not cause or significantly contribute to his demise. He was not ill in the days preceding March 18<sup>th</sup>. Furthermore, the admission hematocrit bilirubin and platelet count were all within acceptable limits. Finally, the spleen showed no histologic evidence of sequestration and sickling was not demonstrated in the other organs and tissues examined.

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